

Terry Marentette

I am honored to have this opportunity to speak today. Thank you! I feel it is imperative that this panel understands the needs of patients before ruling on any legislation amending a law that we the people passed.

I have fibromyalgia, degenerated disc disease, and bare wire in my back. In February, 2012 I was seen by Dr. Malcolm Fields. Upon entering the room he asked "Who's using marijuana?" I'm not going to fix you. After lamination I was told Medical Marijuana is obviously working and he can't help anyway.

Mental Health has taught me to listen to my body.

Ingested oil - Alive and alert

Medibles - Range of motion

Topical Balms and oils - Point of most severe pain

Inhaled - motivates or helps me sleep

My family is full of veterans who served our Country. My father was a Navy man who always wanted me to "Be all that you can be" died at his desk at 43 as manager of the West Branch MESC office, my husband is a disabled veteran, no longer strung out on morphine and can socialize again.

Terry

Without my medicine in all of these forms, I am confined to a walker, without safe access to my medicine I may never be able to bowl a 208 game and 514 series, with my 10[#] ball and breaks between every frame. Currently I am confined to what my caregiver can provide and it was almost lost due to power outages.

Thank you and please remember compassion.

Terry Marentette

a.k.a. Terry Tennant
Haggitt

Montney

1310 S. Gray Rd

West Branch, MI 48661

MEDICAL CENTERS, P.C.

P.O. Box 265
337 E. Houghton Ave.
West Branch, MI 48661
345-5240

P.O. Box 37
158 Tower Hill Road
Houghton Lake, MI 48629
422-5146 or 422-5147

P.O. Box 204
1910 E. Miller Road
Fairview, MI 48621
848-2210

P.O. Box 70
105 W. Main St.
Rose City, MI 48654
685-2612

July 20, 1995
Re: Terry Montney

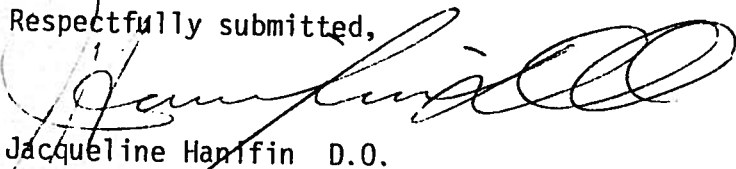
To Whom It May Concern,

Terry Montney is a patient of mine. She has a diagnosis with concurrence of rheumatologist of rheumatic fever and it is a progressive condition that gets more crippling and more painful week by week. This condition leads many patients to severe depression as the condition becomes more debilitating.

Terry is allergic to many analgesic pain killers including narcotics Codeine and Demerol. Terry states she has smoked marijuana occassionally to relieve the pain. This drug does have pain relief effects besides its other effects.

Justice is justice I know, but I understand under extenuating circumstances there is a leniency shown in the courts. I hope that the court understands that this case definitely has extenuating circumstances.

Respectfully submitted,



Jacqueline Hanfin D.O.

MEDICAL NEEDS
Michigan Department of Social Services

INSTRUCTIONS: Please Print or Type

Case Name <u>Montney Terry</u>			
Case Number <u>U13505324</u>		Medical ID Number <u>22356303</u>	
Patient's Name <u>Terry Montney</u>		Patient's Birth Date <u>9-7-56</u>	
County <u>65</u>	District <u>00</u>	Unit <u>02</u>	Worker <u>04</u>
Worker Name <u>Steven Talarico</u>		Worker Phone Number <u>(517) 345-5131</u>	

Physician:

We would appreciate your cooperation in completing the spaces checked below: (In addition to a physician, Box A, expected date of delivery, may be completed by a physician's assistant, certified nurse-midwife, ob-gyn nurse practitioner or ob-gyn clinical nurse specialist as necessary.) An addressed, prepaid envelope is enclosed for your convenience.

You are hereby authorized to release the information requested below to the Department of Social Services.

Patient's or Representative's Signature <u>Terry Montney</u>		Patient's Name <u>Terry Montney</u>	Signature Date <u>11-30-94</u>
Authorized Worker's Signature <u>Steven Talarico</u>		Signature Date <u>11-28-94</u>	Local DSS Office <u>Ogemon</u>
<input type="checkbox"/> A	Pregnancy Delivery (Expected) Date		Number of Medically Verified Unborn Children
<input type="checkbox"/> B	Diagnosis(es) / Treatment Plan for This Patient <u>R.A.</u>		
<input type="checkbox"/> C	Chronic Ongoing Illness <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		
<input type="checkbox"/> D	Estimated Number of Office or Clinic Visits <u>2</u> times per <input type="checkbox"/> week <input checked="" type="checkbox"/> month <input type="checkbox"/> quarter <input type="checkbox"/> Other (Please Specify) _____		Will This <input type="checkbox"/> YES, When _____ Date _____ Change? <input type="checkbox"/> NO
<input type="checkbox"/> E	Give Estimated Number of Months for the Diagnosis in B that Medical Treatment will be Required _____ <input type="checkbox"/> Lifetime		
<input type="checkbox"/> F	Is the Patient Non-ambulatory? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		If Yes, Explain: _____
<input type="checkbox"/> G	Does Patient Need Special Transportation? If Yes Indicate Mode of Transportation Needed (i.e., Van with Wheelchair Lift, Ambulance, Etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
<input type="checkbox"/> H	Does Someone Need to Accompany the Patient to the Medical Appointment? If Yes, Who/Why? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
<input type="checkbox"/> I	Do You Certify the Patient has a Medical Need for Assistance with Any of the Personal Care Activities Listed Below? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		
	Eating Toileting Bathing Grooming	Dressing Transferring Mobility Taking Medications	Meal Preparation Shopping / Errands Laundry Housework
<input type="checkbox"/> J	Can Patient Work at Usual Occupation? <input type="checkbox"/> YES <input type="checkbox"/> YES, But with Limitations (Specify) _____		
	Can Patient Work at Any Job? <input type="checkbox"/> YES <input type="checkbox"/> YES, But with Limitations (Specify) _____		
<input type="checkbox"/> K	Other (Explain) _____		
Date Patient Was Last Seen <u>12-7-94</u>		Provider Signature <u>[Signature]</u>	
Provider Name and Title (Print or Type) <input type="checkbox"/> MD <input checked="" type="checkbox"/> DO <input type="checkbox"/> DDS <u>JACQUELIN HANIFIN</u>		Signature Date <u>12-4-94</u>	Telephone Number <u>345-5240</u>
Are You an MA Enrolled Provider? _____			

MEDICAL EXAMINATION REPORT

Michigan Department of Social Services

INSTRUCTIONS:

er - Attach DSS-93, Medical Services Authorization, Invoice and Pay-Voucher and DSS-1555, Authorization To Release Medical Information.

Ining Physician - Return completed Medical Examination Report and DSS-93 promptly to the County Department of Social Services in the ad self-addressed stamped envelope.

TO PHYSICIAN: The treating physician's examination, opinion and medical reports are essential for information concerning the onset, severity and duration of impairment. Clearly describe any physical or mental impairment or abnormality. Diagnoses and / or symptoms, by themselves, are inadequate to establish a of disability. Significant physical limitations, abnormal laboratory, radiologic, and other diagnostic findings carry greater weight since they're demonstrable. 3 provide a copy of these reports, including any information relative to the diagnosis or treatment of HIV or AIDS, if applicable. PLEASE TYPE OR PRINT RLY.

Case Name <i>Montney Terry</i>		Case Number <i>013505324</i>	
Client's Name (if different)		Date of Birth <i>9-7-56</i>	
County <i>65</i>	District <i>00</i>	Unit <i>01</i>	Worker <i>08</i>
		Recipient ID Number <i>00356303</i>	

HISTORY OF IMPAIRMENT(S) - Describe Below ▶

ONSET DATE

DATE OF SURGERY(IES)

*Pain in back mus since '79 but was able to work
2 yrs ago left work - too painful
Gradual pain increase in arms & legs & joints for last
yrs. Now unable to continue for
Hand pain 3 yrs*

CURRENT DIAGNOSIS

*Chronic fibromyalgia per Rheumatology. Also some
Carpal Tunnel syndrome (bilateral)*

PHYSICAL EXAMINATION

Height

Current Weight

Weight 6 Months Ago

Blood Pressure

Dominant Hand

1: ▶

140

130/80

R

PERTINENT ABNORMAL FINDINGS (i.e., range of motion, edema, neurological deficit, clubbing, etc.)

*Most disability in (R) - shoulder, hip, elbow wrist, legs & arms but
now, at times the (L) " " " " " " pain
& ROM decrease*

SUPPORTING DATA (Please attach copies of all test data)

☐ Laboratory Data:

☐ Radiologic Data:

☐ Other Diagnostic Findings:

CURRENT MEDICATIONS - CHECK BOX IF NONE ☐ (Attach Additional Sheets If Necessary)

Medication Name	Dosage Schedule	Medication Name	Dosage Schedule
<i>Zolft 50 - 9 a's</i>		<i>d.</i>	
<i>Metrex 1 pr</i>		<i>e.</i>	
<i>Robax 200 bid</i>		<i>f.</i>	

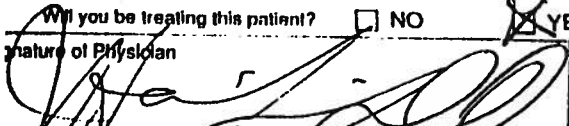
PHYSICAL CAPACITIES EVALUATION - Please complete Item 7A-7E based on your clinical evaluation and / or other test results. Indicate N / A for any item that you cannot answer. Explain the basis for your findings in the right hand column.

1. In an 8-HOUR WORKDAY, the individual should be able to (CIRCLE): • Sit (in hours) 0 1 2 3 4 5 6 7 8 • Stand (in hours) 0 1 2 3 4 5 6 7 8 • Walk (in hours) 0 1 2 3 4 5 6 7 8										A. Based on Finding:
2. Considering your clinical findings only, the individual should be able to LIFT / CARRY: NEVER OCCASIONALLY FREQUENTLY CONTINUOUSLY HOW FAR (FT) • Up to 10 lbs. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> • 11-20 lbs. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> • 21-50 lbs. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> • 51-100 lbs. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>										B. Based on Finding:
3. The individual should be able to use his / her extremities for REPETITIVE ACTION such as: • HANDS / ARMS: NEITHER LEFT RIGHT BOTH • Simple Grasping <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> • Reaching <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> • Pushing & Pulling <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> • Fine Manipulating <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> • FEET / LEGS - • Operating Foot / Leg Controls <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>										C. Based on Finding:
4. The individual should be able to: NEVER OCCASIONALLY FREQUENTLY CONTINUOUSLY • Bend <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> • Squat <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> • Kneel <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> • Crawl <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> • Reach Above Shoulder Level <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>										D. Based on Finding:
5. The individual may be exposed to the following WORKING CONDITIONS: NEVER OCCASIONALLY FREQUENTLY CONTINUOUSLY • Unprotected Heights <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> • Moving Machinery <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> • Noise and Vibration <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> • Extreme Temperatures <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> • Dust, Fumes and Gases <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>										E. Based on Finding:
6. ARE ASSISTIVE DEVICES MEDICALLY REQUIRED AND NEEDED FOR AMBULATION? <input type="checkbox"/> NO <input type="checkbox"/> YES (If YES, please describe) <i>x cane</i>										

RECOMMENDATIONS / COMMENTS / ADDITIONAL REMARKS

Dr Rene concurred that my care was sufficient and so Dr Rene decided specialist's care.

D. TREATMENT

Will you be treating this patient? <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES, If YES ▶	Number of Visits per Month <i>1-2 / month</i>	Number of Months of Treatment <i>lifetime</i>
Signature of Physician 	Printed Name of Physician Dr. Rene	M.D. or D.O. (Specialty, If any)

WEST BRANCH REGIONAL MEDICAL CENTER
John R. Tolfree Health Systems
2463 S. M-30. WEST BRANCH, MI 48661
(989)345-3660

RADIOLOGY REPORT

Patient name:	MARENTETTE TERRY A		
Room:		Birthdate:	09/07/1956
MR#:	8409	Age:	55
Pt#:	30009314	Sex:	F
Phone:	989/345/3509	Admit Phy:	GAFT RICHA
		Ordering Phy:	GAFT RICHA
		Adm Date:	11/15/11

Unsigned transcriptions represent a preliminary report and do not reflect corrections, additions, and/or subtractions to the information contained in this report

MRI LUM SPN W/O 72148 COMPLETE:11/15/11 18:16 CLB 7178
(SPINE PROCED REASON: PAIN

TECHNIQUE: MRI of the lumbar spine without intravenous contrast.

CLINICAL INDICATIONS: Low back pain.

FINDINGS: Multiecho and multiplanar images of the lumbar spine were obtained without administration of intravenous contrast. There is minimal heterogeneity in the bone marrow of the lumbar vertebral bodies probably related to marrow conversion. There is hemangioma involving the T12 vertebral body extending to the pedicle on the right side. The conus ends at normal level.

At L5-S1 level, there is circumferential disk bulge, bilateral facet degenerative changes and ligamentum flavum thickening causing bilateral lateral recess and bilateral neural foraminal narrowing.

At L4-5 level, there is small circumferential disk bulge, bilateral facet degenerative changes and ligamentum flavum thickening causing bilateral lateral recess and bilateral neural foraminal narrowing and mild spinal canal narrowing.

At L3-4 level, there is circumferential disk bulge with superimposed central to right paracentral disk extrusion and in conjunction with facet degenerative changes and ligamentum flavum thickening causing segmental spinal stenosis, right lateral recess stenosis and mass effect on the right L4 nerve root cannot be excluded.

At L2-3 and L1-2 levels, there are minimal facet degenerative changes. Incidental note is made of a simple cortical cyst in the left kidney.

IMPRESSION:

1. Small circumferential disk bulge with moderate-sized central to right paracentral disk extrusion at L3-4 level and in conjunction with facet degenerative changes are causing segmental spinal stenosis and right lateral recess narrowing. Correlate clinically for right L4 radiculopathy.
2. Mild bilateral inferior neural foraminal narrowing at L4-5 and L5-S1 levels from circumferential disk bulge, facet degenerative changes.
3. Nonspecific edema in the subcutaneous soft tissues.

Electronically Reviewed and Signed By
VENKATRAMANA R VATTIPALLY
MD
11/18/11 09:19

WEST BRANCH REGIONAL MEDICAL CENTER
John R. Tolfree Health Systems
2463 S. M-30. WEST BRANCH, MI 48661
(989)345-3660

RADIOLOGY REPORT

Patient name: MARENTETTE TERRY A
Room: Birthdate: 09/07/1956 Admit Phy: GAFT RICHA
MR#: 8409 Age: 55 Ordering Phy: GAFT RICHA
Pt#: 30009314 Sex: F Adm Date: 11/15/11
Phone: 989/345/3509

Unsigned transcriptions represent a preliminary report and do not reflect corrections, additions, and/or subtractions to the information contained in this report

Dictated By: VENKATRAMANA R VATTIPALLY MD
Dictated Date/Time: 11/16/11 08:55
Transcribe Date/Time: 11/17/11 07:46
Transcribe Initials: ALA

Copy for: GAFT RICHARD

via fax

Appt made 11/22/11 @ 1pm
Pt sick
Quint
11/21/11

MID-MICHIGAN FAMILY ORTHOPAEDICS

Mark D. Weber, M.D.
Bernard Wagner, OPA-C

3099

☒ 2333 Progress Road, Suite C
West Branch, MI 48661
(517) 345-7474

☐ Medical Arts Building
295 Maple Street, Suite F
Tawas City, MI 48763
(517) 362-7634

April 21, 1992

Dear Dr. Hanafin:

I saw your patient, Terry Montney, on April 9, 1992. This 35 year old female has had off and on pain in the right wrist and forearm for over three years. She states that she is dropping things. She has not had any hypesthesia or sharp pains from the neck down to the right upper extremity. She has had an extensive blood work up, which, according to the patient, has not revealed any systemic disease.

Examination shows that there is no swelling or atrophy. Neurological examination is normal. There is some tenderness along the palmaris longus and the flexor carpi radialis, as well as along the volar aspect of the wrist. She has pain with range of motion of the wrist, especially with dorsal flexion and volar flexion of the wrist. Grip strength is reduced. She complains of pain in the forearm when she does that.

I ordered a bone scan of the wrist to look for avascular necrosis of the lunate. I have never seen that without joint effusion. I doubt that the bone scan will be positive. I am not sure what is wrong. I feel that this may be a chronic tenosynovitis. Since she is on an anti-inflammatory and uses a wrist brace, I do not have any other treatment. I think that she may have to learn to live with this problem. I do not know of any surgical intervention that will help her.

Sincerely,


Mark D. Weber, M.D.

MW/jp

dictated, not read